MDR: M4-02-4276-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $594.80 for dates of service 05/30/01, and 06/04/01.

   b. The request was received on 02/06/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFA(s)
   c. TWCC 62 forms
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60
   b. TWCC 62 form
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 08/15/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 08/16/02. The initial response from the insurance carrier was received in the Division on 02/08/02. There was no 14 day response.

4. Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Statement on Table of Disputed Services:

"We feel that we are due further reimbursement for the durable medical equipment that we provided this patient with. This equipment is medically necessary and prescribed by the patients [sic] treating doctor. This equipment was billed at a fair and reasonable rate and should have been paid at the full-billed amount. We are requesting additional payments in full with interest."

2. Respondent: "Fair and reasonable payment has been made in accordance with the TWCC Medical Fee Guidelines, as such; the provider is not entitled to further reimbursement on the above referenced disputed service dates."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 05/30/01, and 06/04/01.

2. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
05/30/01	E1399	$75.00 $155.00 $45.00	$0.00 $50.00 $0.00	G G G	DOP DOP DOP	MFG DME; (IV)	CPT code E1399 is not global to any other CPT code billed on this date of service. Therefore, reimbursement is recommended in the amount of **$225.00**. ($275.00 - $50.00 already paid = $225.00).
06/04/01	E0145	$495.00	$125.20	M	DOP (D code 0639 $217.55)	MFG DME; (X)(IV);(IX)(C) TWCC Act & Rules Sec. 413.011 (d)	The provider has included in their dispute packet, documentation (EOBs from other carriers) that provides some evidence of "fair and reasonable" reimbursement per Sec. 413.011(d). However, MFG DME (IX)(C)states:… "A fair and reasonable reimbursement shall be the same as the fees set for the "D" codes in the 1991 Medical Fee Guideline." "D" code 0639 listed in the MFG DME, has the same description as HCPCS code E0145. The MAR for 0639 is $217.55. Therefore, reimbursement is recommended in the amount of **$92.35. (**217.55 - $125.20 already paid = $92.35).
Totals		$770.00	$175.20				The Requestor **is** entitled to additional reimbursement in the amount of **$317.35.**

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $317.35 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 7th day of February 2003.

Michael Bucklin
Medical Dispute Resolution Officer
Medical Review Division
MB/mb